

DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT HUACHUCA, AZ 85613-7079

MEDDAC Memo 40-165

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Medical Services
MEDICAL RECORD & PEER REVIEW PROGRAM

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1. HISTORY. This issue publishes a revision of this publication

2. PURPOSE. The purpose of this policy is to define the professional staff's role in conducting administrative medical record review and medical staff peer review in one integrated, multidisciplinary process. Peer review recommendations and results will be considered in the privileging process IAW the organizational rules and regulations of the medical staff.

3. REFERENCES.

3.1 Comprehensive Accreditation Manual for Ambulatory Care Joint Commission on Accreditation of Healthcare Organizations, current edition.

3.2 AR 40-68, Clinical Quality Management, current edition.

3.3 MEDDAC Memo 15-1, Committee Structure, current edition.

3.4 MEDDAC Memo 40-27, Patient Safety (PS)/Risk Management (RM) Programs, current edition

3.5 RWBAHC Rules and Regulations of the Medical Staff.

4. SCOPE. This policy is applicable to all clinical staff.

This memorandum supersedes MEDDAC Memo 40-165, dtd 12 August 2003.

5. RESPONSIBILITIES.

5.1 The Commander, will provide appropriate command oversight of the program.

5.2 The Executive Committee (EXCOM) will - in conjunction with the Executive Committee of the Professional Staff (ECOPS) - approve the written program policy.

5.3 The Executive Committee of the Professional Staff (ECOPS) will - in conjunction with the Executive Committee (EXCOM) - approve the written program policy.

5.4 The Deputy Commander for Clinical Services (DCCS) will serve as the proponent of the program, and implement the program in the patient care areas. Administrative and clinical staff under the supervision of the DCCS will perform data collection for both medical record review and general peer review.

5.5 The Medical Record Review Committee will:

5.5.1 Ensure medical record review procedures conform to JCAHO and other regulatory standards.

5.5.2 Perform data aggregation and analysis - as well as propose conclusions and recommendations for ongoing program performance improvement to the Credentials Committee and ECOPS

5.5.3 Submit any recommendations for focused practitioner performance reviews to the Risk Management Committee for further appropriate action.

5.6 The Credentials Committee will:

5.6.1 Ensure peer review procedures conform to JCAHO and other regulatory standards.

5.6.2 Utilize provider specific peer review data in the privileging process of providers.

5.7 The Risk Management Committee will:

5.7.1 Perform focused practitioner performance reviews on cases referred from other individuals or committees.

5.7.2 Manage Potentially Compensable Events (PCEs) IAW MEDDAC Memo 40-27, Patient Safety (PS)/Risk Management (RM) Programs.

5.7.3 Forward systemic issues to ECOPS for resolution.

5.8 The Patient Advocate will collect, review, and trend provider specific patient satisfaction data and forward this information to the Risk Management Coordinator and the DCCS.

5.9 Licensed Independent Practitioners (LIP) will use tools validated and authorized by the organization to conduct objective peer reviews and use acknowledged standards of care within the community, relevant literature and clinical practice guidelines as a benchmark.

6. PEER REVIEW PROCEDURES:

6.1 Peers: A Peer is defined in Appendix A. No peer will review his/her own cases or - if in a financial relationship with a partner - those of his/her partners.

6.1.2 Peer review will be conducted using standardized criteria for peer review defined by the organization and include - but are not limited to the variables listed on the organization's approved peer review tool located at the following link: <https://rwbahches/meps/medtrends/> The organizational peer review tool is formatted as a survey available on the intranet to all RWBAHC staff. Peer review data collection is the responsibility of the organization's Department Chiefs. The proponent for the peer review data aggregation process, which is designed to be automated, is the Chief, Information Management Division - under the guidance of the DCCS. The proponent for peer review data analysis is the Chairman of the Medical Records Review Committee.

6.1.3 Sample size: The organizational standard for sample size is 1 record/provider/week for all clinics: The organizational standard for moderate sedation and general anesthesia encounters is 100% of all cases.

6.1.4 Procedure for LIPs with no on-site peer: If the peer review is unable to be performed at this facility an external peer review will be requested from a peer from another MTF or network practice.

6.1.5 The following criteria will initiate a Focused Practitioner Performance Review:

6.1.5.1 A sentinel event or near-miss reported to the Risk Management Committee

6.1.5.2 A significant departure from established practice patterns noted during a general peer review.

6.1.5.3 The commander or a member of the medical staff requests a focused review on a specific provider.

6.1.5.4 A beneficiary questions the appropriateness of care in a patient concern or other format.

7. MEDICAL RECORD REVIEW PROCEDURES: Staff in the organization's various patient care areas will conduct administrative medical record reviews using the same medical records and format as used for the peer review process. The organization has defined variables for review that pertain to patient specific information IAW JCAHO Management of Information elements of performance, the use of the MEDCOM Clinical Practice Guidelines, and the RWBAHC Coding Compliance Plan.

The proponent of this publication is the Deputy Commander for Clinical Services and Chief, Quality Management Division. Users are invited to send their comments and suggestions on DA 2028, to USA MEDDAC, ATTN: MCXJ-QM, Fort Huachuca, AZ 85613-7079.

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APPENDIX A

DEFINITIONS

Medical Record Review: An ongoing, periodic **administrative** review of a representative sample of outpatient records (OPR) and/or clinic continuity folders that focus on patient specific information and other necessary administrative documentation as defined by the organization.

General Peer Review: An ongoing, periodic **clinical** review of a representative sample of outpatient records (OPR) and/or clinic continuity folders that focuses on provider-specific adequacy of documentation of the provision of patient care.

Focused Practitioner Performance Review: A review conducted on specific systemic or provider issues when any of the following criteria are met:

Adverse Event: An untoward, undesirable, and usually unanticipated event, i.e., the death of a patient, employee, or visitor in a health care organization.

Deviation: Any variation from the accepted standards of care, practice or performance.

Fallouts. Any peer review resulting in a non-concur, major variance, PCE, or Sentinel Event.

Peer: A Licensed Independent Practitioner (LIP) who is a credentialed in the same specialty or sub-specialty, and with essentially the same qualifications and scope of practice as the LIP undergoing peer review. No peer will review his/her own cases or - if in a financial relationship with a partner - those of his/her partners.

Peer Review: The process of selectively reviewing a representative sample of patient encounters by a peer in order to ensure that the documentation and provision patient care meets reasonable standards.

Potentially Compensable Event (PCE): An incident where a breach of the standard of care may have occurred resulting in injury or sequelae, with the possibility of adverse legal action.

Standard of Care: Identified, documented, and generally accepted levels of care that serve as clinical guidelines for the delivery of safe and effective patient care and patient response to that care within a variety of clinical situations.